under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 6695–1 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed after December 31, 2008.

[T.D. 9436, 73 FR 78457, Dec. 22, 2008; 74 FR 5106, Jan. 29, 2009]

§ 44.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax on wagers under sections 4401 or 4411, the rules under § 1.6696–1 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

§ 44.7262–1 Failure to pay special tax.

Any person liable for the special tax who does any act which makes him liable for such tax, without having paid the tax, is, besides being liable for the tax, subject to a fine of not less than $1,000 and not more than $5,000.

§ 44.7701–1 Tax return preparer.

(a) *In general.* For the definition of a tax return preparer, see § 301.7701–15 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

PART 46—EXCISE TAX ON CERTAIN INSURANCE POLICIES, SELF–INSURED HEALTH PLANS, AND OBLIGATIONS NOT IN REGISTERED FORM

Subpart A—Introduction

Sec.

Subpart B—Tax on Policies Issued by Foreign Insurers

Subpart C—Fees on Insured and Self-insured Health Plans

Subpart D—Excise Tax on Obligations Not in Registered Form

AUTHORITY: 26 U.S.C. 7805.

SOURCE: T.D. 8497, 25 FR 6461, May 6, 1960, unless otherwise noted.

Subpart A—Introduction

§ 46.0–1 Introduction.

The regulations in this part 46 relate to the taxes on certain insurance policies and self-insured health plans imposed by chapter 34 of the Internal Revenue Code and the tax on the issuer of registration-required obligations not issued in registered form imposed by chapter 39 of the Internal Revenue Code. See part 40 of this chapter for regulations relating to returns, payments, and deposits of taxes imposed by chapters 34 and 39.

[T.D. 8442, 57 FR 48185, Oct. 22, 1992, as amended by T.D. 9602, 77 FR 72728, Dec. 6, 2012]

Subpart B—Tax on Policies Issued by Foreign Insurers

§ 46.4371–1 Applicability of subpart.

The provisions of this subpart apply only to premiums paid on or after January 1, 1966. See subpart H, part 47 of this chapter for provisions relating to premiums paid or charged before January 1, 1966. If any portion of the tax imposed by section 4371 was paid on the basis of the premium charged before January 1, 1966, in accordance with the

provisions of §47.4371–2 of this chapter (documentary stamp tax), then, to the extent that such portion was paid by stamp, no further tax is due under the provisions of this subpart.

§46.4371–2 Imposition of tax on policies issued by foreign insurers; scope of tax.

(a) *Certain insurance policies, and indemnity, fidelity, or surety bonds.* Section 4371(1) imposes a tax upon each policy of insurance (other than those referred to in paragraph (b) of this section), upon each indemnity, fidelity, or surety bond, or upon each certificate, binder, covering note, receipt, memorandum, cablegram, letter, or other instrument by whatever name called, whereby a contract of insurance or an obligation in the nature of an indemnity, fidelity, or surety bond is made, continued, or renewed, if issued:

(1) By a nonresident alien individual, a foreign partnership, or a foreign corporation, as insurer (unless the policy or other instrument is signed or countersigned by an officer or agent of the insurer in a State, Territory, or the District of Columbia in which the insurer is authorized to do business); and either

(2) To or for, or in the name of, a domestic corporation, domestic partnership, or an individual resident of the United States, against or with respect to hazards, risks, losses, or liabilities wholly or partly within the United States; or

(3) To or for, or in the name of, a foreign corporation, foreign partnership, or nonresident individual, engaged in a trade or business within the United States with respect to hazards, risks, or liabilities wholly within the United States.

For definition of the term ''indemnity bond,'' see section 4372(c).

(b) *Life insurance, sickness, and accident policies, and annuity contracts.* Unless the insurer is subject to tax under section 819, section 4371(2) imposes a tax upon each policy of insurance or annuity contract, or upon each certificate, binder, covering note, receipt, memorandum, cablegram, letter, or other instrument by whatever name called, whereby a contract of insurance or an annuity contract is made, continued, or renewed, if issued:

(1) By a nonresident alien individual, a foreign partnership, or a foreign corporation, as insurer (unless the policy or other instrument is signed or countersigned by an officer or agent of the insurer in a State, Territory, or the District of Columbia in which such insurer is authorized to do business); and

(2) To any person with respect to the life or hazards to the person of a citizen or resident of the United States.

(c) *Reinsurance.* Section 4371(3) imposes a tax upon each policy of reinsurance, certificate, binder, covering note, receipt, memorandum, cablegram, letter, or other instrument by whatever name called, whereby a contract of reinsurance is made, continued, or renewed, if issued:

(1) By a nonresident alien individual, a foreign partnership, or a foreign corporation, as reinsurer (unless the policy or other instrument is signed or countersigned by an officer or agent of the reinsurer in a State, Territory, or the District of Columbia in which such reinsurer is authorized to do business); and

(2) To any person against, or with respect to, any of the hazards, risks, losses, or liabilities covered by contracts of the type described in section 4371 (1) or (2).

(d) *Exempt indemnity bonds.* The tax imposed by section 4371 does not apply to any indemnity bond described in section 4373(2).

§46.4371–3 Rate and computation of tax.

(a) *Rate of tax.* (1) The tax under section 4371(1) is imposed at the rate of 4 cents on each dollar, or fractional part thereof, of the premium payment.

(2) The tax under section 4371 (2) and (3) is imposed at the rate of 1 cent on each dollar, or fractional part thereof, of the premium payment.

(b) *Meaning of premium payment.* For purposes of this subpart, the term ''premium payment'' means the consideration paid for assuming and carrying the risk or obligation, and includes any additional assessment or charge paid under the contract, whether payable in one sum or installments.

§ 46.4371–4 Records required with respect to foreign insurance policies.

(a) Each person required under the provisions of § 46.4374–1 to remit the tax imposed by section 4371 shall keep or cause to be kept accurate records of all policies or other instruments subject to such tax upon which premiums have been paid. Such records must identify each such policy or other instrument in such a manner as to clearly establish the following: (1) The gross premium paid; (2) whether such policy or other instrument is (i) a policy of casualty insurance or an indemnity bond subject to tax under section 4371(1), (ii) a policy of life, sickness, or accident insurance or an annuity contract subject to tax under section 4371(2), or (iii) a policy of reinsurance subject to tax under section 4371(3); (3) the identity of the insured (as defined in section 4372(d)); (4) the identity of the foreign insurer or reinsurer (as defined in section 4372(a)); and (5) the total premium charged and, if the premium is to be paid in installments, the amount and anniversary date of each such installment.

(b) The records required under the provisions of this section must be kept on file at the place of business or at some other convenient location, for a period of at least 3 years from the date any part of the tax became due or the date any part of the tax is paid, whichever is later, in such manner as to be readily accessible to authorized internal revenue officers or employees. The person having control or possession of a policy or other instrument subject to tax under section 4371 shall retain such policy or other instrument for at least 3 years from the date any part of the tax with respect to such policy was paid.

[T.D. 7023, 35 FR 1012, Jan. 24, 1970. Redesignated by T.D. 8328, 56 FR 189, Jan. 3, 1991, as amended by T.D. 8442, 57 FR 48186, Oct, 22, 1992]

§ 46.4374–1 Liability for tax.

(a) *In general.* Any person who makes, signs, issues, or sells any of the documents and instruments subject to the tax, or for whose use or benefit the same are made, signed, issued, or sold, shall be liable for the tax imposed by section 4371. For purposes of this section, in the case of a reinsurance policy that is subject to the tax imposed by section 4371(3), other than assumption reinsurance, the insured person on the underlying insurance policy, the risk of which is covered in whole or in part by such reinsurance policy, shall not constitute a person for whose use or benefit the reinsurance policy is made, signed, issued, or sold.

(b) *When liability for tax attaches.* The liability for the tax imposed by section 4371 shall attach at the time the premium payment is transferred to the foreign insurer or reinsurer (including transfers to any bank, trust fund, or similar recipient, designated by the foreign insurer or reinsurer), or to any nonresident agent, solicitor, or broker. A person required to pay tax under this section may remit such tax before the time the tax attaches if he keeps records consistent with such practice.

(c) *Payment of tax.* The tax imposed by section 4371 shall be paid on the basis of a return by the person who makes payment of the premium to a foreign insurer or reinsurer or to any nonresident agent, solicitor, or broker. If the tax is not paid by the person who paid the premium, the tax imposed by section 4371 shall be paid on the basis of a return by any person who makes, signs, issues, or sells any of the documents or instruments subject to the tax imposed by section 4371, or for whose use or benefit such document or instrument is made, signed, issued, or sold.

(d) *Penalty for failure to pay tax.* Any person who fails to comply with the requirements of this section with intent to evade the tax shall, in addition to other penalties provided therefor, pay a fine of double the amount of tax. (*See* section 7270.)

(e) *Effective date.* This section is applicable for premiums paid on or after November 27, 2002.

[T.D. 9024, 67 FR 70846, Nov. 27, 2002]

Subpart C—Fees on Insured and Self-insured Health Plans

SOURCE: T.D. 9602, 77 FR 72728, Dec. 6, 2012, unless otherwise noted.

§ 46.4375–1 Fee on issuers of specified health insurance policies.

(a) *In general.* An issuer of a specified health insurance policy is liable for a fee imposed by section 4375 for policy years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides definitions that apply for purposes of section 4375 and this section. Paragraph (c) of this section provides rules for calculating the fee under section 4375. Paragraph (d) of this section provides the applicability date. For rules relating to filing the required return and paying the fee, see §§ 40.6011(a)–1 and 40.6071(a)–1 of this chapter.

(b) *Definitions.* The following definitions apply for purposes of section 4375 and this section. See also § 46.4377–1 for additional definitions.

(1) *Specified health insurance policy*—(i) *In general.* Except as provided in paragraph (b)(1)(ii) of this section and § 46.4377–1, *specified health insurance policy* means any accident and health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States (as defined in § 46.4377–1(a)(2)), including prepaid health coverage arrangements described in paragraph (b)(2) of this section. *Specified health insurance policy* also includes any policy that provides accident and health coverage to an active employee, former employee, or qualifying beneficiary, as continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other Federal law or state law.

(ii) *Exceptions.* The term *specified health insurance policy* does not include—

(A) Any insurance policy if substantially all of its coverage is of excepted benefits described in section 9832(c);

(B) Any group policy issued to an employer where the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the United States (as defined in § 46.4377–1(a)(3));

(C) Any stop loss or indemnity reinsurance policy; or

(D) Any insurance policy to the extent it provides an employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

(iii) *Stop loss policy.* For purposes of paragraph (b)(1)(ii) of this section, *stop loss policy* means an insurance policy in which—

(A) The insurer that issues the policy to a person establishing or maintaining a self-insured health plan becomes liable for all, or an agreed upon portion of, losses that person incurs in covering the applicable lives in excess of a specified amount; and

(B) The person establishing or maintaining the self-insured health plan retains its liability to, and its contractual relationship with, the applicable lives covered.

(iv) *Indemnity reinsurance policy.* For purposes of paragraph (b)(1)(ii) of this section, *indemnity reinsurance policy* means an agreement between two or more insurance companies under which—

(A) The reinsuring company agrees to accept and to indemnify the issuing company for all or part of the risk of loss under policies specified in the agreement; and

(B) The issuing company retains its liability to, and its contractual relationship with, the applicable lives covered.

(2) *Prepaid health coverage arrangement.* The term *prepaid health coverage arrangement* means an arrangement under which fixed payments or premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident and health coverage to individuals residing in the United States, regardless of how such coverage is provided or arranged to be provided. For example, any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract is a specified health insurance policy.

(c) *Calculation of fee*—(1) *In general.* The amount of the fee for a policy for a policy year is equal to the product of the average number of lives covered under the policy for the policy year

(determined in accordance with paragraphs (c)(2) and (c)(3) of this section) and the applicable dollar amount (determined in accordance with paragraph (c)(4) of this section). For purposes of computing the fee under this paragraph (c), in the case of an issuer that determines the average number of lives covered for all policies in effect during a calendar year using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section, the applicable dollar amount with respect to such issuer's policies for such calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year (determined in accordance with paragraph (c)(4) of this section), except that the applicable dollar amount with respect to such an issuer's policies for calendar year 2019 is the applicable dollar amount for policy years ending on September 30, 2019. For more information, see the examples in paragraphs (c)(2)(iii)(B), (c)(2)(iv)(B), (c)(2)(v)(B), and (c)(2)(vi)(B) of this section.

(2) *Determination of the average number of lives covered under a policy*—(i) *In general.* To determine the average number of lives covered under a specified health insurance policy during a policy year, an issuer must use one of the following methods—

(A) The actual count method (described in paragraph (c)(2)(iii) of this section);

(B) The snapshot method (described in paragraph (c)(2)(iv) of this section);

(C) The member months method (described in paragraph (c)(2)(v) of this section); or

(D) The state form method (described in paragraph (c)(2)(vi) of this section).

(ii) *Consistency requirements.* An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, ''Quarterly Federal Excise Tax Return,'' for a particular year, the issuer must use the same method of computing lives covered. An issuer that determines the average number of lives covered by using the actual count method described in paragraph (c)(2)(iii) of this section or the snapshot method described in paragraph (c)(2)(iv) of this section may change its method of computing the average lives covered to the snapshot method or actual count method, respectively, provided that the issuer uses the same method for computing the average lives covered for all policies for which a liability is reported on the Form 720 for that year. For example, an issuer with a policy having a policy year that ends on June 30, Policy A, may determine the average number of lives covered under Policy A for July 1, 2013, to June 30, 2014, using the actual count method if the issuer uses the actual count method for all policies for which a liability will be reported on the Form 720 due by July 31, 2015 (the due date for return that will include the liability for the July 2013 to June 2014 policy year for Policy A). The issuer may change its method for determining the average number of lives covered under Policy A to the snapshot method for the July 1, 2014, to June 30, 2015, policy year, provided that the snapshot method is used for all policies for which a liability will be reported on the Form 720 due by July 31, 2016 (the due date for return that will include the liability for the July 2014 to June 2015 policy year for Policy A). An issuer that determines the average number of lives covered by using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section must use the same method for calculating lives covered for all policy years for which the fee applies.

(iii) *Actual count method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered for each day of the policy year and dividing that total by the number of days in the policy year.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iii)(A) of this section:

Example. Insurance Company A issues three policies that are in effect during 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which

has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company A must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company A chooses to use the actual count method under paragraph (c)(2)(iii)(A) of this section to determine average lives covered for policies having a policy year that ends in 2014. Insurance Company A calculates the sum of lives covered under Policy A for each day of the policy year ending November 30, 2014, as 3,285,000. The average number of lives covered under Policy A for the policy year ending November 30, 2014, is 3,285,000 divided by 365, or 9,000. Insurance Company A calculates the sum of lives covered under Policy B for each day of the policy year ending February 28, 2014, as 547,500. The average number of lives covered under Policy B for the policy year ending on February 28, 2014, is 547,500 divided by 365, or 1,500. Insurance Company A calculates the sum of lives covered under Policy C for each day of the policy year ending December 31, 2014, as 4,380,000. The average number of lives covered under Policy C for the policy year ending December 31, 2014, is 4,380,000 divided by 365, or 12,000. To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company A must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the average number of lives covered for that policy. Insurance Company A then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(iv) *Snapshot method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under a policy for a policy year by adding the totals of lives covered on a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter), and dividing that total by the number of dates on which a count is made. For purposes of this paragraph (c)(2)(iv)(A), each date used for the second, third and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must be within the same policy year. If an issuer uses multiple dates for the first quarter, the issuer must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of such corresponding dates, and all dates used must be within the same policy year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used as a counting date for a calendar year policy, June 30 is the corresponding date for the second quarter).

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iv)(A) of this section:

Example. (i) Insurance Company B issues three policies with 12-month policy years that end in 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company B must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company B chooses to determine the average lives covered using the snapshot method for all policies that have a policy year that ends in 2014 and chooses to count lives covered on a single date of the first month of each quarter of the policy years. Thus, for Policy A, Insurance Company B must count lives covered on a single date falling in each of December 2013, March 2014, June 2014 and September 2014; for Policy B, Insurance Company B must count lives covered on a single date falling in each of March 2014, June 2014, September 2014 and December 2014; and for Policy C, Insurance Company B must count lives covered on a single date falling in each of January 2014, April 2014, July 2014 and October 2014. In addition, the date for each of the second, third, and fourth quarters must fall within three days of the date in such quarter that corresponds to the date used for the first quarter, and must fall within the same policy year.

(ii) On December 6, 2013, Policy A covers 8,900 lives, on March 7, 2014, 9,100 lives, on June 6, 2014, 9,050 lives, and on September 5, 2014, 9,050 lives. Insurance Company B treats the average number of lives covered under Policy A for the policy year ending November 30, 2014, as 36,100 (8,900 + 9,100 + 9,050 + 9,050) divided by 4, or 9,025.

(iii) On March 4, 2013, Policy B covers 1,500 lives, on June 7, 2013, 1,350 lives, on September 6, 2013, 1,400 lives, and on December 6,

2013, 1,550 lives. Insurance Company B treats the average number of lives covered under Policy B for the policy year ending February 28, 2014, as 5,800 (1,500 + 1,350 + 1,400 + 1,550) divided by 4, or 1,450.

(iv) On January 6, 2014, Policy C covers 12,500 lives, on April 4, 2014, 12,250 lives, on July 7, 2014, 12,000 lives, and on October 3, 2014, 11,250 lives. Insurance Company B treats the average number of lives covered under Policy C for the policy year ending December 31, 2014, as 47,750 (12,500 + 12,250 + 12,000 + 11,250) divided by 4, or 12,000.

(v) To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company B must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the number of average lives covered for that policy. Insurance Company B then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(v) *Member months method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

Example. Insurance Company C chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the member months method of paragraph (c)(2)(v)(A) of this section. Insurance Company C reports 12,000,000 as its member months on the NAIC Supplemental Health Care Exhibit filed for calendar year 2013. Under the member months method, Insurance Company C calculates the average number of lives covered for all its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company C multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(vi) *State form method*—(A) *Calculation method.* An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state of domicile and a method similar to that described in paragraph (c)(2)(v) of this section, if the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(vi)(A) of this section:

Example. Insurance Company D is not required to file the NAIC Supplemental Health Care Exhibit, but files a form with its state of domicile. Insurance Company D chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the state form method of paragraph (c)(2)(vi)(A) of this section. The state form reports the number of lives covered in the same manner as member months is reported on the NAIC Supplemental Health Care Exhibit. For calendar year 2013, Insurance Company D reports 12,000,000 as its equivalent member months on the state form. Under the state form method, Insurance Company D calculates the average number of lives covered for all of its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (equivalent member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company D multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(3) *Special rules for the first year and the last year the fee is in effect*—(i) *Calculation of the average number of lives covered under the policy for the first year the fee is in effect.* For issuers that determine the average number of lives covered using data reported on the 2012 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2012 calendar year, the average number of lives covered under all policies in effect for the 2012 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this

section) multiplied by ¼. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the actual count method under paragraph (c)(2)(iii) of this section may calculate the average number of lives covered using data from the period beginning May 14, 2012, through the end of the policy year. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the snapshot method under paragraph (c)(2)(iv) of this section may calculate the average number of lives covered using dates from the quarters remaining in the policy year starting on or after May 14, 2012. If an abbreviated year is used, the issuer will divide the number of lives covered by the number of days from May 14, 2012, through the end of the policy year (for the actual count method) or the number of days on which a count was made (for the snapshot method).

(ii) *Calculation of the average number of lives covered under the policy for the last year the fee is in effect.* For issuers that determine the average number of lives covered using data reported on the 2019 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2019 calendar year, the average number of lives covered for all policies in effect during the 2019 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by ¾. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after January 1, 2019, and before October 1, 2019.

(iii) *Examples.* The following examples illustrate the principles of paragraph (c)(3) of this section:

Example 1. Insurance Company E issues Group Health Insurance Policy C, which has a policy year that ends on November 30, 2012. Insurance Company E determines the average number of lives covered under a policy by using the actual count method. Under that method, for that policy year, Insurance Company E calculates the sum of lives covered under Policy C for each day between May 14, 2012, and November 30, 2012, as 10,000. The average number of lives covered under Policy C for that policy year is 10,000 divided by the number of days from May 14, 2012, through November 30, 2012. Alternatively, Insurance Company E could have counted the number of lives covered for the entire policy year and divided the sum by 365.

Example 2. Insurance Company F reports 12,000,000 as its member months on its NAIC Supplemental Health Care Exhibit filed for calendar year 2012. Under the member months method, Insurance Company F calculates the average number of lives covered for 2012 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), and then multiplying the result (1,000,000) by ¼, which equals 250,000. Accordingly, the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013, is 250,000.

(4) *Applicable dollar amount.* For policy years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1. For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2. For any policy year ending in any Federal fiscal year beginning on or after October 1, 2014, the applicable dollar amount is the sum of—

(i) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; and

(B) The percentage increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the Federal fiscal year.

(d) *Effective/Applicability date.* This section applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019.

§ 46.4376–1 Fee on sponsors of self-insured health plans.

(a) *In general*—(1) *General rule.* A plan sponsor of an applicable self-insured health plan is liable for a fee imposed by section 4376 for plans with plan years ending on or after October 1, 2012,

and before October 1, 2019. Paragraph (b) of this section provides the definitions that apply for purposes of section 4376 and this section. Paragraph (c) of this section provides the requirements for calculating the fee imposed by section 4376. Paragraph (d) of this section provides the applicability date. For rules relating to filing the required return and paying the fee, see §§ 40.6011(a)–1 and 40.6071(a)–1.

(2) [Reserved]

(b) *Definitions.* The following definitions apply for purposes of section 4376 and this section. See § 46.4377–1 for additional definitions.

(1) *Applicable self-insured health plan*—(i) *In general.* Except as provided in paragraph (b)(1)(ii) of this section and § 46.4377–1, *applicable self-insured health plan* means a plan that provides for accident and health coverage (within the meaning of § 46.4377–1(a)) if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained—

(A) By one or more employers for the benefit of their employees or former employees;

(B) By one or more employee organizations for the benefit of their members or former members;

(C) Jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees;

(D) By a voluntary employees' beneficiary association, as described in section 501(c)(9);

(E) By an organization described in section 501(c)(6); or

(F) By a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA)), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural cooperative association (as defined in section 3(40)(B)(v) of ERISA).

(ii) *Exceptions.* The term *applicable self-insured health plan* does not include any of the following:

(A) A plan that provides benefits substantially all of which are excepted benefits, as defined in section 9832(c). For example, a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) that satisfies the requirements to be treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) of this chapter is not an applicable self-insured health plan. A health FSA that is not treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) is an applicable self-insured health plan.

(B) An employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

(C) A plan that, as demonstrated by the facts and circumstances surrounding the adoption and operation of the plan, was designed specifically to cover primarily employees who are working and residing outside the United States (as defined in § 46.4377–1(a)(3)).

(iii) *Multiple self-insured arrangements established or maintained by the same plan sponsor.* For purposes of section 4376, two or more arrangements established or maintained by the same plan sponsor that provide for accident and health coverage (within the meaning of § 46.4377–1(a)) other than through an insurance policy and that have the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee imposed by section 4376. For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits, and a separate self-insured arrangement with the same plan year providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan for purposes of calculating the fee. Similarly, if a plan sponsor provides a Health Reimbursement Arrangement (HRA) and another applicable self-insured health plan that provides major medical coverage, the HRA and the major medical plan may be treated as one applicable self-insured health plan if the HRA and the self-insured plan have the same plan year.

(iv) *Examples.* The following examples illustrate the principle of this paragraph (b)(1):

Example 1. (i) Plan Sponsor D sponsors and maintains three separate plans to provide

certain benefits to its employees—Plan 501, Plan 502, and Plan 503.

(ii) Plan 501 is a calendar year plan that provides accident and health benefits, other than through insurance (that is, on a self-insured basis), to employees of Plan Sponsor D. Plan 502 is a calendar year HRA that can be used to pay for qualified accident and medical expenses for employees of Plan Sponsor D and their eligible dependents. Plan 503 provides dental and vision benefits for employees of Plan Sponsor D and eligible dependents, other than through insurance (that is, on a self-insured basis).

(iii) Because Plan 501 and Plan 502 provide accident and health coverage (within the meaning of § 46.4377–1(a)) and are maintained by Plan Sponsor D for the benefit of its employees, Plans 501 and 502 are applicable self-insured health plans that are subject to the fee imposed by section 4376. Because dental and vision benefits are excepted benefits, as defined in section 9832(c), Plan 503 is not an applicable self-insured health plan subject to the section 4376 fee. Under the special rule set forth in § 46.4376–2(b)(1)(iii), Plan Sponsor D may treat Plans 501 and 502 (both self-insured plans with a calendar year plan year) as a single plan for purposes of calculating the fee imposed by section 4376.

Example 2. Same facts as *Example 1*, except Plan 503 is not a Plan that provides dental and vision benefits, but rather a plan that provides accident and health coverage solely to employees who are working and residing outside the United States and does not provide any benefits to employees who are not working and residing outside the United States. Plan 503 is designed specifically to provide coverage to employees working and residing outside the United States because it limits coverage to these employees. Therefore, in accordance with the exception described in § 46.4376–1(b)(1)(ii)(C), Plan 503 is not an applicable self-insured health plan.

(2) *Plan sponsor*—(i) *In general.* The term *plan sponsor* means—

(A) The employer, in the case of an applicable self-insured health plan established or maintained by a single employer;

(B) The employee organization, in the case of an applicable self-insured health plan established or maintained by an employee organization;

(C) The joint board of trustees, in the case of a multiemployer plan (as defined in section 414(f));

(D) The committee, in the case of a multiple employer welfare arrangement (as defined in section 3(40) of ERISA);

(E) The cooperative or association that establishes or maintains an applicable self-insured health plan established or maintained by a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA) or rural cooperative association (as defined in section 3(40)(B)(v) of ERISA);

(F) The trustee, in the case of an applicable self-insured health plan established or maintained by a voluntary employees' beneficiary association (meaning that the voluntary employees' beneficiary association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person); or

(G) In the case of an applicable self-insured health plan the plan sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, the person identified by the terms of the document under which the plan is operated as the plan sponsor, or the person designated by the terms of the document under which the plan is operated as the plan sponsor for section 4376 purposes, provided that designation is made in writing, and that person has consented to the designation in writing, by no later than the date by which the return paying the fee under section 4376 for that plan year is required to be filed, after which date that designation for that plan year may not be changed or revoked, and provided further that a person may be designated as the plan sponsor only if the person is one of the persons establishing or maintaining the plan (for example, one of the employers that establishes or maintains the plan with one or more other employers or employee organizations).

(H) In the case of an applicable self-insured health plan the sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, and for which no identification or designation of a plan sponsor has been made pursuant to paragraph (b)(2)(i)(G) of this section, each employer that establishes or maintains the plan (with respect to employees of that employer), each employee organization that establishes or maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative, or association that establishes or maintains the plan,

meaning that each plan sponsor must file a separate Form 720, ''Quarterly Federal Excise Tax Return,'' reflecting its separate liability under section 4376.

(ii) *Examples.* The following examples illustrate the principles of paragraph (b)(2) of this section:

Example 1. (i) Corporation XYZ is a holding company with no employees that owns all the issued and outstanding shares of Employer X, Employer Y, and Employer Z. Employer X, Employer Y, and Employer Z have established the XYZ Group Health Plan to provide accident and health coverage, provided other than through an insurance policy, for the benefit of their employees. The XYZ Group Health Plan has a calendar year plan year. In addition, there is no plan sponsor identified or designated in the plan document.

(ii) Because the XYZ Group Health Plan provides accident and health coverage other than through an insurance policy, and is established by one or more employers for the benefit of their employees, the XYZ Group Health Plan is an applicable self-insured health plan under section 4376(c)(2)(A) and paragraph (b)(1)(i)(A) of this section. Because a plan sponsor is not identified or designated in the governing plan document, the plan sponsor, for purposes of section 4376, is determined under paragraph (b)(2)(i)(H) of this section as each employer that establishes or maintains the plan (Employer X, Employer Y, and Employer Z), each with respect to its employees covered under the plan. Accordingly, Employer X, Employer Y, and Employer Z each must file a Form 720 reflecting their separate liabilities under section 4376, calculated based on lives covered that are employees of that employer (or spouses, dependents, or other beneficiaries of employees of that employer) and the applicable dollar amount in effect for the plan year.

Example 2. The same facts as *Example 1,* except that the governing plan document designates Employer X as the plan sponsor of the XYZ Group Health Plan for purposes of the fee under section 4376 and Employer X consents to this designation no later than the due date for paying the fee under section 4376. Accordingly, the plan sponsor for purposes of section 4376 is determined under paragraph (b)(2)(i)(G) of this section as Employer X. Employer X must file a Form 720 reflecting liabilities under section 4376, calculated based upon lives covered that are employees of Employer X, Employer Y, or Employer Z, or spouses, dependents, or other beneficiaries of employees of those employers and the applicable dollar amount in effect for the plan year.

(c) *Calculation of fee*—(1) *In general.* The amount of the fee for a plan year is equal to the product of the average number of lives covered under the plan for the plan year (determined in accordance with paragraph (c)(2) of this section) and the applicable dollar amount (determined in accordance with paragraph (c)(3) of this section).

(2) *Determination of the average number of lives covered under the plan*—(i) *In general.* To determine the average number of lives covered under an applicable self-insured health plan during a plan year, a plan sponsor must use one of the following methods—

(A) The actual count method (described in paragraph (c)(2)(iii) of this section);

(B) The snapshot method (described in paragraph (c)(2)(iv) of this section); or

(C) The Form 5500 method (described in paragraph (c)(2)(v) of this section).

(ii) *Consistency within plan year.* A plan sponsor must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. However, a plan sponsor may use a different method from one plan year to the next.

(iii) *Actual count method*—(A) *In general.* A plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered for each day of the plan year and dividing that total by the number of days in the plan year.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iii)(A) of this section:

Example. Employer A is the plan sponsor of the Employer A Self-Insured Health Plan, which has a calendar year plan year. Employer A calculates the sum of lives covered under the plan for each day of the plan year ending December 31, 2013 as 3,285,000. The average number of lives covered under the plan for the plan year ending December 31, 2013, is 3,285,000 divided by 365, or 9,000. To calculate the section 4376 fee for the plan under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer A must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 9,000.

(iv) *Snapshot method*—(A) *In general.* A plan sponsor may determine the average number of lives covered under an

applicable self-insured health plan for a plan year by adding the totals of lives covered on a date during the first, second, or third month of each quarter of the plan year (or more dates in each quarter if an equal number of dates is used in each quarter), and dividing that total by the number of dates on which a count was made. For purposes of this paragraph (c)(2)(iv), each date used for the second, third and fourth quarter must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same plan year. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of such corresponding dates, and all dates used must fall within the same plan year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used for a calendar year plan, June 30 is the corresponding date for the second quarter). For purposes of this paragraph (c)(2)(iv), the number of lives covered on a designated date may be determined using either the snapshot factor method described in paragraph (c)(2)(iv)(B) of this section or the snapshot count method described in paragraph (c)(2)(iv)(C) of this section.

(B) *Snapshot factor method.* Under the snapshot factor method, the number of lives covered on a date is equal to the sum of—

(*i*) The number of participants with self-only coverage on that date; plus

(*ii*) The number of participants with coverage other than self-only coverage on the date multiplied by 2.35.

(C) *Snapshot count method.* Under the snapshot count method, the number of lives covered on a date equals the actual number of lives covered on the designated date.

(D) *Examples.* The following examples illustrate the principles of paragraphs (c)(1) and (c)(2)(iv) of this section:

Example 1. (i) Employer B is the plan sponsor of the Employer B Self-Insured Health Plan, which has a calendar year plan year. Employer B uses the snapshot method to determine the average number of lives covered under the plan and uses the snapshot count method to determine the number of lives covered on a day in the first month of each calendar quarter of the plan year.

(ii) On January 4, 2013, the Employer B Self-Insured Health Plan covers 2,000 lives, on April 5, 2013, 2,100 lives, on July 5, 2013, 2,050 lives, and on October 4, 2013, 2,050 lives. Under the snapshot method, Employer B must determine the average number of lives covered under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013, as 8,200 (2,000 + 2,100 + 2,050 + 2,050) divided by 4, or 2,050. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,050.

Example 2. (i) Same facts as *Example 1*, except that for the 2014 plan year Employer B determines the number of lives covered that are not covered by self-only coverage using the snapshot factor method (that is, based on the number of participants with coverage other than self-only coverage multiplied by 2.35 (the factor set forth in (c)(2)(iv) of this section)).

(ii) On January 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 11, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 11, 2014 and October 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees.

(iii) Under the snapshot factor method, Employer B must determine the average number of lives covered under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2014 as 9,988 [(600 + (800 × 2.35)) + (608 + (800 × 2.35)) + (610 + (809 × 2.35)) + (610 + (809 × 2.35))] divided by 4, or 2,497. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2014, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,497.

(v) *Form 5500 method*—(A) *Calculation method.* A plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of participants reported on the Form 5500, ''Annual Return/Report of Employee Benefit Plan,'' or the Form 5500–SF, ''Short Form Annual

Return/Report of Small Employee Benefit Plan,'' that is filed for the applicable self-insured health plan for that plan year, provided that the Form 5500 or Form 5500–SF is filed no later than the due date for the fee imposed by section 4376 for that plan year. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 or Form 5500–SF for the applicable self-insured health plan, divided by 2. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 or Form 5500–SF filed for the applicable self-insured health plan.

(B) *Examples.* The following examples illustrate the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

Example 1. Employer C is the plan sponsor of the Employer C Self-Insured Health Plan, which has a calendar year plan year ending on December 31, 2013. Employer C is required to file a Form 5500 for the plan for the 2013 plan year by July 31, 2014. However, on July 30, 2014, Employer C obtains an automatic 2½ month extension for filing the 2013 Form 5500. Employer C files the 2013 Form 5500 on September 30, 2014 (that is, before the October 15 extended due date). Employer C is not eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending on December 31, 2013, because the 2013 Form 5500 was not filed by the original due date (that is, by July 31, 2014) for the return that reports liability for the fee imposed by section 4376 for the 2013 plan year.

Example 2. Same facts as *Example 1*, except that the Employer C Self-Insured Health Plan has a fiscal year plan year ending on July 31, 2013, and offers only self-only coverage. Employer C files a Form 5500 for the Employer C Self-Insured Health Plan for the plan year ending July 31, 2013 (the 2012 Form 5500), on the extended due date for filing the 2012 Form 5500 (May 15, 2014). Employer C is eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending on July 31, 2013, because the 2012 Form 5500 had been filed by the due date for the return that reports liability for the fee imposed by section 4376 for that plan year (July 31, 2014).

Example 3. Same facts as *Example 2*, provided further that the Employer C Self-Insured Health Plan 2012 Form 5500 reports 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the 2012 plan year. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of lives covered for the plan year ending July 31, 2013, as equal to the sum of 4,000 and 4,200 or 8,200, divided by 2, or 4,100. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 4,100.

Example 4. Same facts as *Example 3*, except that the Employer C Self-Insured Health plan offers self-only coverage and family coverage. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of lives covered for the plan year ending July 31, 2013, as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 8,200.

(vi) *Special rule for health FSAs and HRAs.* For purposes of this section, if a plan sponsor does not establish or maintain an applicable self-insured health plan other than a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) or a health reimbursement arrangement (as described in Notice 2002–45 (2002–2 CB 93)) (HRA), the plan sponsor may treat each participant's health FSA or HRA as covering a single life (and therefore the plan sponsor is not required to include as lives covered any spouse, dependent, or other beneficiary of the individual participant in the health FSA or HRA, as applicable). If a health FSA or HRA that is an applicable self-insured health plan has the same plan sponsor and plan year as another applicable self-insured health plan other than a health FSA or HRA, the two arrangements may be treated as a single plan under paragraph (b)(1)(iii) of this section. However, the special counting rule in this paragraph applies only for purposes of the health FSA or HRA and, therefore, applies only for purposes of the participants in the health

FSA or HRA that do not participate in the other applicable self-insured health plan. The participants in the health FSA or HRA that participate in the other applicable self-insured health plan will be counted in accordance with the method applied for counting lives covered under that other plan as described in paragraph (b)(2)(i) of this section. See § 601.601(d)(2) of this chapter.

(vii) *Special rule for lives covered solely by the fully-insured options under an applicable self-insured health plan*—(A) *In general.* If an applicable self-insured health plan provides accident and health coverage through fully-insured options and self-insured options, the plan sponsor is permitted to disregard the lives that are covered solely under the fully-insured options in determining the lives covered taken into account for the actual count method (described in paragraph (c)(2)(iii) of this section), the snapshot method (described in paragraph (c)(2)(iv) of this section), and the Form 5500 method (described in paragraph (c)(2)(v) of this section).

(B) *Example.* The following example illustrates the principles of paragraph (c)(2)(vii) of this section:

Example. (i) Employer C is the plan sponsor of the Employer C Health Plan (Plan P). The Plan offers self-only or family health and accident coverage under fully-insured or self-insured options. On June 28, 2015, Employer C files a Form 5500 for Plan P for the plan year ending December 31, 2014 indicating: (1) a total of 4,000 plan participants on the first day of the 2014 plan year; and (2) a total of 4,200 plan participants on the last day of the plan year. Employer C determines that there were 3,000 plan participants (and their families, as applicable) covered under the fully-insured option offered under the plan on the first day of the 2014 plan year, and 2,900 plan participants (and their families, as applicable) covered under the fully-insured option on the last day of the 2014 plan year. Employer C uses the Form 5500 method to calculate the number of lives covered for the 2014 plan year.

(ii) Pursuant to paragraph (c)(2)(vii) of this section, Employer C determines the number of lives covered for the 2014 plan year as: the sum of 1,000 (4,000 total participants on the first day of the plan year—3,000 participants covered by the specified health insurance policy on the first day of the plan year) and 1,300 (4,200 total participants—2,900 participants covered by the specified health insurance policy on the first day of the plan year), or 2,300. To calculate the section 4376 fee under paragraph (c)(1) of this section for the 2014 plan year, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,300.

(viii) *Special rule for the first year the fee is in effect.* Notwithstanding paragraph (c)(2)(i) of this section, for a plan year beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

(3) *Applicable dollar amount.* For a plan year ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1. For a plan year ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2. For any plan year ending in any Federal fiscal year beginning on or after October 1, 2014, the applicable dollar amount is equal to the sum of—

(i) The applicable dollar amount for the plan year ending in the previous Federal fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for the plan year ending in the previous Federal fiscal year; and

(B) The percentage increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the Federal fiscal year.

(4) *Examples.* The following examples illustrate the principle of paragraph (c)(3) of this section.

Example 1. (Calendar year plan). (i) Plan Sponsor C maintains Plan X which has a calendar year plan year; the plan continues in operation for the entire calendar years 2012 through 2019. Plan X is an applicable self-insured health plan, within the meaning of § 46.4376–1(b)(1), and Plan Sponsor C is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year—the plan year beginning January 1, 2012, and ending December 31, 2012—and ending with the 2018 plan year—the plan year beginning January 1, 2018, and ending December 31, 2018. In accordance with § 40.6071(a)–1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section

4376 for Plan X covers the 2012 plan year (January 1, 2012, through December 31, 2012) and must be filed no later than July 31, 2013, and the fee reported on this form must be calculated by multiplying the average number lives by $1 (the applicable dollar amount in effect for plans with plan years beginning on or after October 1, 2012, and before October 1, 2013); and

(ii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (January 1, 2018, through December 31, 2018) and must be filed no later than July 31, 2019, and the fee reported on this form must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

Example 2. (Fiscal year plan). (i) Plan Sponsor B maintains Plan W, which has a fiscal year plan year ending on July 31; the plan continues in operation for the entire fiscal year plan years from August 1, 2012, through July 31, 2019. Plan W is an applicable self-insured health plan, within the meaning of § 46.4376–1(b)(1), and Plan Sponsor B is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year—the plan year beginning on August 1, 2012, and ending on July 31, 2013—and ending with the 2018 plan year—plan year beginning on August 1, 2018, and ending July 31, 2019. In accordance with § 40.6071(a)–1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2012 plan year (August 1, 2012, through July 31, 2013) and must be filed no later than July 31, 2014, and the fee reported on this form must be calculated by multiplying the average number lives by $1 (the applicable dollar amount in effect for plans with plans years beginning on or after October 1, 2012, and before October 1, 2013); and

(iii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (August 1, 2018, through July 31, 2019) and must be filed no later than July 31, 2020, and the fee must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

(d) *Effective/Applicability date.* This section applies for plan years that end on or after October 1, 2012, and before October 1, 2019.

§ 46.4377–1 Definitions and special rules.

(a) *Definitions.* The following definitions apply for purposes of sections 4375 and 4376 and §§ 46.4375–1 and 46.4376–1.

(1) *Accident and health coverage.* The term *accident and health coverage* means any coverage that, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c) and § 46.4375–1(b)(1)). Accident and health coverage also includes coverage for an active employee, a former employee, or a qualifying beneficiary that is continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other federal law or under state law.

(2) *Individual residing in the United States*—(i) The term *individual residing in the United States* means an individual with a place of abode in the United States.

(ii) *Determination of place of abode.* For purposes of paragraph (a)(2) of this section, an issuer or a plan sponsor may rely on the most recent address on file with the issuer or plan sponsor and may treat the primary insured and the primary insured's spouse, dependents, or other beneficiaries covered by the policy as having the same place of abode. For this purpose, the primary insured is the individual covered by the policy whose eligibility for coverage was not due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual.

(3) *United States.* The term *United States* includes American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and any other possession of the United States.

(4) *Federal fiscal year.* The term *Federal fiscal year* means the year beginning on October 1 and ending on the following September 30.

(b) *Treatment of exempt governmental programs*—(1) *In general.* The fees imposed by sections 4375 and 4376 do not apply to any covered life under an exempt governmental program as defined in paragraph (b)(2) of this section.

(2) *Exempt governmental program.* For purposes of this section, *exempt governmental program* means any—

(i) Insurance program established under title XVIII of the Social Security Act;

(ii) Medical assistance program established by title XIX or XXI of the Social Security Act;

(iii) Program established by Federal law for providing medical care (other than through insurance policies) to individuals (or their spouses and dependents) by reason of such individuals being (or having been) members of the Armed Forces of the United States; and

(iv) Program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

(c) *Effective/Applicability date.* This section applies to all policy and plan years that end on or after October 1, 2012, and before October 1, 2019.

Subpart D—Excise Tax on Obligations Not in Registered Form

§ 46.4701–1 Tax on issuer of registration-required obligation not in registered form.

(a) *In general.* Section 4701 imposes a tax (determined under paragraph (c) of this section) on any person (referred to as the issuer) who issues an obligation that—

(1) Is a registration-required obligation, and

(2) Is not issued in registered form.

(b) *Definitions*—(1) *Person.* The term ''person'' includes all governmental entities.

(2) *Obligation.* The term ''obligation'' includes bonds debentures, notes, certificates and other evidences of indebtedness regardless of how denominated.

(3) *Registration-required obligation.* The term ''registration-required obligation'' has the same meaning as when used in section 163(f) (and the regulations thereunder) which relates to the denial of a deduction for interest on certain obligations not in registered form. However, the term ''registration-required obligation'' does not include any obligation which would otherwise be exempt from Federal income tax under section 103(a) or any other provision of law.

(4) *Registered form.* The term ''registered form'' has the same meaning as when used in section 103(j) (and the regulations thereunder) which relates to obligations which must be in registered form to be tax-exempt.

(5) *Issuer.* Except as provided in §1.163–5T(d) (relating to pass-through certificates) and §1.163–5T(e) (relating to REMICs), the ''issuer'' is the person whose interest deduction would be disallowed solely by reason of section 163(f)(1).

(6) *Date of Issuance.* (i) For obligations intended to be offered to the public, the term ''date of issuance'' means the date the obligation is first sold to the public at the issue price.

(ii) For an obligation which is privately placed, the term ''date of issuance'' is the date the obligation is first sold by the issuer.

(7) *Issue price.* See section 1273 (b) and the regulations thereunder for the definition of ''issue price''.

(c) *Rate and computation of tax.* The tax under section 4701(a) is imposed in an amount equal to the product of—

(1) 1 percent of the principal amount of the obligation, multiplied by

(2) The number of calendar years (or portions thereof) during the period beginning on the date of issuance of the obligation and ending on the date of maturity.

For purposes of this paragraph, the term ''principal amount'' for a discounted obligation is the issue price, and for all other obligations, including obligations sold at a premium, the term ''principal amount'' is the stated redemption price at maturity.

(d) *Payment of tax.* Every person who incurs liability for the tax imposed by section 4701 is required to file a return in accordance with section 6011 and §46.6011(a)–1 relating to the general requirement of a return, statement or list.

(e) *Effective date.* The provisions of this section shall apply to obligations issued after December 31, 1982, unless issued on the exercise of a warrant or the conversion of a convertible obligation if the warrant or obligation was offered or sold outside the United States without registration under the Securities Act of 1933 and was issued before August 10, 1982. See section

310(d)(3) of the Tax Equity and Fiscal Responsibility Act of 1982.

[T.D. 8102, 51 FR 33594, Sept. 22, 1986; 51 FR 36392, Oct. 10, 1986, as amended by T.D. 8300, 55 FR 19627, May 10, 1990]

PART 48—MANUFACTURERS AND RETAILERS EXCISE TAXES

Subpart A—Introduction

Subparts B–E [Reserved]

Subpart F—Special Fuels

Subpart G—Fuel Used on Inland Waterways

Subpart H—Motor Vehicles, Tires, Tubes, Tread Rubber, and Taxable Fuel